

Health Plus Surgical Center, LLC
CitiMed Services
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Surgical Booking Form

Patient Information					
LAST	FIRST	MI	Gender	DOB	AGE
STREET ADDRESS			SOCIAL SECURITY #		
CITY	STATE	ZIP	EMERGENCY CONTACT		
HOME #	WORK #	CELL #	EMERGENCY #		
Surgical Procedure Information					
SURGEON Ketan D Vora, DO			ASSISTING SURGEON		
REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE	
PRIMARY PROCEDURE NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4
Pre-Operative Medical Clearance					
DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE?		IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:			
<input type="checkbox"/> YES <input type="checkbox"/> NO					
DOES THE PATIENT REQUIRE AN EKG?		PATIENT HEIGHT		PATIENT WEIGHT	
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Special Requests					
EQUIPMENT		SUPPLIES			
INSTRUMENTATION		OTHER			
Insurance Information					
IS THIS WORKMAN'S COMP?	PLEASE ATTACH		CASE CLAIM #	DATE OF INJURY	
IS THIS NO FAULT?	AUTHORIZATION LETTER				
IS THIS PRIVATE HEALTH INS?					
IS THIS A LIEN?	ATTORNEY NAME		ATTORNEY PHONE #		
PLEASE ATTACH SIGNED LIEN					
PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN		SUBSCRIBER DOB	
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN		SUBSCRIBER DOB	
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
EMPLOYER NAME	EMPLOYER ADDRESS		EMPLOYER PHONE #		
Insurance Pre-Certification Authorization					
INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE(Adjuster)		AUTH #	DATE OF AUTH.	
Surgeon's Scheduler's Information					
NAME		PHONE #		FAX #	
Treating Physical Therapy Office					
NAME		PHONE #		ADDRESS	
Transportation:					
<input type="checkbox"/> YES <input type="checkbox"/> NO					